

**World Health Organization
Department of Mental Health and Substance Abuse
Geneva, Switzerland**

Meeting of the International Advisory Group
for the Revision of ICD-10 Mental and Behavioural Disorders
11 – 12 March, 2008, Geneva SWITZERLAND

Meeting Summary Report

The third meeting of the International Advisory Group (AG) for the Revision of ICD-10 Mental and Behavioural Disorders was held in Geneva during 11 – 12 March 2008. The AG was constituted by WHO with the primary task of advising WHO on all steps leading to the revision of the mental and behavioural disorders classification in ICD-10 in line with the overall revision process. A list of participants in this meeting is provided in the Annex.

This Summary Report provides a summary of the conclusions reached during the meeting.

1. *Opening Remarks*

The meeting was opened by Dr. Ala Alwan, Assistant Director General, Noncommunicable Diseases and Mental Health. Dr. Alwan emphasized the importance of the revised ICD Mental and Behavioural Disorders classification as a tool for improving services for people with mental disorders and to encourage accountability among governments for their efforts to reduce the substantial disease burden associated with them.

2. *Large groups of diagnoses and entities and spectra*

Introduced by Dr. Gavin Andrews

Presentations by Dr. Robert Krueger, Dr. William Carpenter, Dr. David Goldberg, and Dr. Gavin Andrews

The purpose of this series of presentations was to introduce a proposed re-conceptualization of the large groups of mental disorders currently found in ICD-10. This re-conceptualization relates to how disorders are grouped together into classes and not to the criteria for individual diagnoses. This conceptual schema was offered as a basis for discussion by the AG, and not as a completed project.

The proposed grouping is based on several factors, including symptom presentation, risk factors, treatment response, and other biological, cognitive, and emotional characteristics. Based on the available information, four large clusters of disorders were proposed, which were the focus of the subsequent presentations. It is important to note that the names used in this report to refer to these clusters are simply for the purpose of clarity, and with the AG's awareness that a more complete discussion of terminology would be needed.

Dr. Krueger reviewed evidence from a variety of studies indicating that common mental disorders separate into two correlated clusters, which have been labelled Internalizing and Externalizing. He also presented data suggesting that the Internalizing Disorders cluster further separates into Distress (e.g., depression, dysthymia, generalized anxiety disorder) and Fear (e.g., phobias, panic disorder). The evidence for the coherence of the Externalizing cluster includes genetic effects, course in early adulthood, and neural correlates, in addition to phenomenological similarities. Prototypic examples of disorders in the Externalizing cluster are those related to alcohol and substance use, conduct disorder, adult antisocial personality disorder, and possibly the hyperactivity component of ADHD.

Dr. Carpenter argued that the current classificatory structure for psychotic disorder fails to define similarities and differences among disorders that result in specific and discrete classification. The

current over-specification and arbitrary grouping of disorders has contributed to problems in both research and practice. The conceptualization of treatments at a cluster level and the identification of key similarities and differences among disorders within clusters would help to refine the research and therapeutic issues. Evidence for the coherence of the Psychotic Disorders cluster comes from research on biomarkers, environmental and genetic influences on psychotic disorders, family studies of schizophrenia spectrum, neural substrates, cognitive and emotional factors, co-morbidity, and treatment response. The disorders in this cluster include those that are currently classified as psychotic disorders, as well as bipolar disorder and some forms of personality disorder.

Dr. Goldberg presented evidence for common features within the cluster of Internalizing Disorders. These disorders are characterized by distress experienced inwardly, and related to the emotions of anxiety, depression and fear. Although diagnostic criteria are specific to each disorder, many symptoms are shared so that a wide range of common disorders may be identified by superficial screening. As symptom severity increases, the symptoms that differentiate among the disorders appear. Disorders in this cluster share common environmental risk factors and substantial similarities in cognitive and emotional processes (e.g., high negative affectivity or “neuroticism”). Available treatments are generally effective across disorders within the cluster (e.g., SSRIs, cognitive behaviour therapy). Internalizing disorders include generalized anxiety, panic disorder, specific phobias, social phobias, obsessional states, dysthymic disorders, neurasthenia, somatoform disorders, post-traumatic stress disorder, and non-psychotic forms of depression.

Dr. Andrews presented findings relevant to a cluster of disorders characterized by neurocognitive deficit, usually associated with permanent neural loss. Dr. Andrews argued that clustering these disorders together can help to facilitate diagnosis, improve treatment processes, improve prognosis by facilitating early identification and treatment, and inform research. Disorders in this cluster share some genetic and environmental risk factors. Treatments that are effective for disorders within this cluster are not disorder-specific, and also typically effective for other disorders within the cluster (e.g., anticholine esterase inhibitors, antipsychotic medications, cognitive behaviour therapy). At the same time, this cluster was recognized as the most disparate of the four presented.

The AG acknowledged that this approach would represent a major change in classification, but viewed the proposed approach as a potential basis for the development of a more clinically useful system, both for multidisciplinary mental health professionals and in primary care settings. The approach is intuitively appealing, easily understandable, roughly corresponds to the way in which mental health care is often organized, and provides a useful correction to the over-specification that characterizes current classification systems. At the same time, the AG noted several limitations and reservations about the proposed approach, in particular regarding the coherence of a single cluster of neurocognitive disorders. The AG discussed the idea of a separate cluster for disorders that can be considered under the rubric of developmental disorders. There was also considerable discussion about the names for the clusters.

Based on the AG’s discussion, Drs. Andrews and Goldberg were asked to prepare a more complete “straw man” grouping as a basis for further discussion. This second iteration, presented on the second day, included the notable addition of a category for Bodily Disorders (e.g., eating disorders, sleep disorders, sexual disorders) and the separation of developmental disorders and mental retardation from neurocognitive disorders such as delirium and depression. A number of additional issues were raised regarding the revised proposal, but there was not sufficient time for the AG to discuss them thoroughly. Further development of the proposal will be reported at the AG’s next meeting.

3. *Progress in the overall ICD revision*

Introduced by Dr. Bedirhan Üstün and Mr. Can Celik

Dr. Üstün reminded the AG that the goals of the revision are to develop a multi-purpose and coherent classification with logical linkages to available health-related terminologies and ontologies. ICD-11 should function seamlessly in an electronic health records environment and serve as an international

and multilingual reference standard for scientific comparability and communication purposes. Specific challenges for this revision include: to achieve comparable and consistent data across health information systems; to managing the transition from legacy systems; and to involve multiple stakeholders on a large scale to capture and synthesize information.

Web-based tools are available for enhanced communication among individuals involved in the revision process, via three primary methods:

- 1) The ICD Update and Revision Platform is a web-based application that allows any user to post proposals or comments and to review other proposals and comment on them.
- 2) The ICD-11 draft will be a WIKI-like joint authoring tool, designed for use by ICD-11 Technical Advisory Group (TAG) and WHO editors in the specification of taxonomic rules, definitions and diagnostic criteria.
- 3) The ICD terminology provides the basis of the information model linking between ICD and SNOWMED-CT, other ontology and terminologies, and clinical interface algorithms.

The timeline for the revision process is as follows: the Alpha draft version of ICD-11 should be completed in 2010, followed by 1 year for commentary and consultation. The Beta draft version should be completed in 2011, followed by field trials, analysis of field trial data, and revision during the subsequent 2 years. The final version for public viewing should be completed in 2013, with approval by the World Health Assembly in 2014.

4. Progress on Coordinating Groups

Reports from three Coordinating Groups established by the AG were presented and discussed. The AG noted that these groups had been appointed for the 2-year period of 2007 – 2008.

A. Global Scientific Partnership Coordination Group

Introduced by Dr. Norman Sartorius

The Global Scientific Partnership Coordination Group was established to assist the AG in ensuring continued involvement of and input from scientists around the world during the revision process. The group has created a Global Scientific Partnership Network that is intended as an important scientific resource for the AG. This network will facilitate identification and use of key scientific papers, particularly from countries mainly using languages other than English. Its tasks also include identification and evaluation of country-level or regional adaptation of ICD Mental and Behavioural Disorders. The AG commended Dr. Sartorius for the group's progress and plans, and expects that Dr. Sartorius will be in close communication with the AG Chair and the Secretariat as the group's work proceeds.

B. Stakeholder Input and Partnership Coordination Group

Introduced by Dr. Juan Mezzich and Dr. Benedetto Saraceno

The purpose of this group was to stimulate input, collaboration, and commitment to implementation among the three primary groups of WHO constituents: 1) users/consumers of mental health services and their families; 2) multidisciplinary mental health professionals and other relevant health professionals; and 3) governments of WHO member states.

The AG recognized the important and valuable resources represented by World Psychiatric Association (WPA), its Section on Classification and Diagnostic Assessment, and the WPA Global Network of Classification and Diagnostic Groups. The AG also believes that it is important to develop relationships with other groups of relevant professional associations, beginning with those represented on the AG. These organizations should be encouraged to develop infrastructures to

enable participation, such as WPA has done. In terms of service users and family members, the WHO Secretariat will identify groups who may be in a position to participate constructively in the revision process and a plan for communicating with them about the revision. In relation to governments, the Secretariat has already initiated communication with a number of member states, as evidenced by the participation of their representatives at AG meetings. In view of the current nature and range of tasks related to stakeholder coordination and input, the Terms of Reference and composition of this group will be reviewed at the Fall AG meeting.

C. ICD-DSM Harmonization Group

Introduced by Dr. Shekhar Saxena

The task of this group is to facilitate the achievement of the highest possible extent of uniformity and harmonization between ICD-11 mental and behavioural disorders and DSM-V disorders and their diagnostic criteria. Dr. Saxena emphasized the genuine desire of both organizations to achieve harmonization of the two systems. He described a variety of specific issues related to differences between the DSM and the ICD-10 that are important areas of discussion by the Harmonization Group. The AG endorsed the following statement intended to guide the WHO representatives in their activities as part of the ICD-DSM Harmonization Group: “WHO and APA should make all attempts to ensure that in their core versions, the category names, glossary descriptions and criteria are identical for ICD and DSM. Adaptations of the ICD should be directly translatable into the core version.”

5. *Contributions of epidemiology: Report from the ad-hoc group*

Introduced by Dr. Somnath Chatterji

At its September, 2007 meeting, the AG appointed Dr. Oye Gureje, Dr. Maria Elena Medina-Mora, Dr. Andrews, and Dr. Goldberg to work with Dr. Chatterji to consider the needs to epidemiological data and analyses as a part of the AG’s work. Dr. Chatterji provided a discussion of ways in which epidemiological data would make an important contribution to decisions about the classification system. For example, using available epidemiological datasets, from the World Mental Health Survey as well as other studies, the effects on or proposed changes on parameters such as case identification and prevalence. The AG was in full agreement regarding the relevance and importance of epidemiological data in the revision process. The AG recommended that an open call be issued for epidemiological information relevant to series of specific questions based on the information presented by Dr. Chatterji. This may help to distribute the resource demands of time-intensive re-analyses of epidemiological datasets. The AG recommended formalization of this ad-hoc group as a Coordinating Group reporting to the AG.

6. *Report on progress and plans on public health aspects of diagnoses and classification*

Introduced by Dr. Norman Sartorius

The *WHO/APIRE Conference on Public Health Aspects of Diagnosis and Classification of Mental Disorders* was held during 26 – 27 September, 2007, immediately following the most recent AG meeting. As Co-Chair of that conference, Dr. Sartorius provided a summary to the AG. The conference produced the following outcomes: 1) Ten background papers regarding the public health implications of diagnosis and classification of mental disorders were developed; 2) A series of recommendations from a public health perspective regarding the revision of mental disorders diagnosis and classification systems; and 3) Summary recommendations from the previous conferences in the APIRE series on diagnosis, reviewed and revised in order to best serve public health needs. The background papers developed for the conference will be finalized for publication as part of a joint WHO/APIRE publication, and the recommendations considered as they relate to both DSM and ICD.

7. Research versus clinical diagnoses

Introduced by Dr. Shekhar Saxena and Dr. Norman Sartorius

Dr. Saxena provided a brief overview of the history of the development of the different versions of the ICD-10 Chapter V and the DSM-IV. In the case of ICD-10, the *Clinical Descriptions and Diagnostic Guidelines* for mental and behavioural disorders were developed first, and the *Diagnostic Criteria for Research* were published a year later.

The AG decided to devote more of its time to discussion of the “large groups” or categories of disorders, so the series of presentations that had been planned for this item was truncated. The AG has already established its intention to develop a comprehensive ICD-11 that can be viewed at different levels of detail for different purposes. These “views” would be developed simultaneously and in integrated form, rather than being based on different conceptualizations. The question of how the disorders are aggregated in large groups is a fundamental part of this process.

The AG placed a priority on the development of a user-friendly classification system for clinical applications, including for use in primary care. It would also be important to develop a version with more specific criteria to meet the requirements of researchers, in close collaboration with the DSM group. The AG will need to have additional discussion of the need for different versions as the revision process proceeds.

8. Reports from representatives of federations/associations

A. WONCA

Comments by Dr. Michael Klinkman

Dr. Klinkman provided a discussion of relationship between ICD-10 and mental health concepts included in the International Classification of Primary Care (ICPC), which has been accepted by WHO as a related classification. A revision of the ICPC is currently underway, with its completion planned within two and a half year.

B. International Council of Nurses

Comments by Dr Amy Coenen

Dr Coenen presented an overview about the International Council of Nurses (ICN). Members of the ICN include 129 national associations of nurses, each representing one country. The ICN’s mission is “to represent nursing worldwide, advancing the profession and influencing health policy.” The pillars of ICN programmatic activity are professional practice, social and economic welfare of nurses, and nursing regulation. Dr Coenen also described the International Classification of Nursing Practice (ICNP), which is a standard ontology that includes nursing diagnoses, nursing interventions, and outcomes of nursing care. Dr Coenen recommended that the ICD revision be examined for compatibility with the ICNP, in addition to other structured terminologies.

C. International Union of Psychological Science

Comments by Dr. Geoffrey Reed

Dr. Reed presented an overview of the International Union of Psychological Science (IUPsyS), which is an umbrella organization of national or regional associations representing psychologists in more than 70 countries. IUPsyS’s mission is to support “the development of psychological science, whether biological or social, normal or abnormal, pure or applied”. In characterizing psychological practice as it relates to the ICD revision, a challenge is presented by the major international differences in professional requirements. The authorization of psychologists to make diagnoses, and therefore their use of a diagnostic classification system and capacity to participate in the ICD revision process will differ from country to country in relation to the standard of training for practice. Dr. Reed suggested that there is a need for more involvement of multidisciplinary mental health

professionals in specifying use requirements, establishing the development process, and conducting field trials. To accomplish this, international associations of health professionals must develop an infrastructure that enables such participation.

D. World Psychiatric Association

Comments by Dr. Juan Mezzich

Dr. Mezzich presented the perspective of the World Psychiatric Association (WPA) on the ICD revision. WPA is committed to full collaboration with the WHO in developing the ICD-11 and related classifications. WPA will engage its Section on Classification and Diagnostic Assessment, other scientific sections, member societies, and members of the WPA Global Network of Classification and Diagnosis Groups in this process. Dr. Mezzich presented recent publications and additional contributions of WPA that are relevant to the ICD revision, such as the organization of symposia on international classification and diagnostic systems and the WPA Institutional Program on Psychiatry for the Person.

E. International Federation of Social Workers

Comments by Mr. Rolf Blickle-Ritter

Mr. Blickle-Ritter described the perspective of the International Federation of Social Workers (IFSW) related to the ICD revision process. The profession of social work defines itself on the basis of acting for and with the person, emphasizing the characteristics of the person instead of the diagnosis, including strengths as well as deficits, and viewing the person within his or her social context. The Federation is establishing a reference group in relation to the ICD revision process in order to raise awareness and to solicit input on the questions of relevance to the AG. The Federation believes that the revision process should emphasize the public health purposes of diagnosis, helping to improve access to treatment all over the world, to educate the public about mental disorders, and to involve more people in the treatment and recovery process. The Federation believes that a version of the ICD-11 for use in primary care would be more attractive to social workers, and therefore result in wider training, dissemination, and implementation of the system.

The AG requested that the representatives of professional organizations to the AG develop methods for soliciting comments from their groups regarding the issues that are under discussion. Representatives should provide summary feedback from these comment processes to the AG, with specific and individual comments submitted through the ICD Update and Revision Platform. Professional association representatives were asked to disseminate information about the platform to their members and to obtain as much input as possible over the next year. This will increase the active involvement of the organizations, but also help to ensure input from a range of mental health professionals.

9. Future plans for coordinating and working groups

Introduced by Benedetto Saraceno

As noted, the existing coordinating and working groups of the AG were established at the beginning of 2007 and intended to have a life of two years. At its Fall 2008 meeting, the AG will review the need for, Terms of Reference, and composition of existing groups, and propose changes it views as necessary at that time. The AG itself was also appointed for a 2-year period through the end of 2008, and the Chair and Secretariat will review its composition in relationship to the ongoing needs of the revision effort. It would be helpful for more member states to designate representatives and support their participation. The AG recommended that two new working groups be established with immediate effect: A working group on epidemiology and one on the “large groups” to provide input to the AG and to inform the work of the ICD-DSM Harmonization Group.



WORLD HEALTH
ORGANIZATION

3rd Meeting of the Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders

11 - 12 March 2008 Geneva, SWITZERLAND

Venue: Conference Room B, 3rd floor, WHO Main building

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